February 17, 2015

HOUSE BILL No. 1043

DIGEST OF HB 1043 (Updated February 16, 2015 1:30 pm - DI 123)

Citations Affected: IC 34-18.

Synopsis: Medical malpractice caps. Increases the medical malpractice cap from $1,250,000 to $1,650,000 for claims arising after June 30, 2015. Provides that payments from the patient's compensation fund are to be disbursed not later than 60 days after the issuance of a final, nonappealable judgment. Increases pay for medical review panel members from $350 to $500. Increases potential pay for the medical review panel chairperson from $2,000 to $2,500. Increases the maximum potential liability of a qualified health care provider for an occurrence of malpractice from $250,000 to: (1) $300,000; or (2) $400,000 if the action against the health care provider results in a final judgment in favor of the plaintiff. Eliminates provisions under which the liability of a qualified health care provider or the qualified health care provider's insurer could be discharged through a periodic payments agreement under which the cost borne by the qualified health care provider or the qualified health care provider's insurer (consisting of the present payment and the cost of future payments) could be less than the cost of discharging the liability solely through an immediate payment.

Effective: July 1, 2016.

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January 6, 2015, read first time and referred to Committee on Judiciary.
February 17, 2015, amended, reported — Do Pass.

February 17, 2015

First Regular Session of the 119th General Assembly (2015)

PRINTING CODE. Amendments: Whenever an existing statute (or a section of the Indiana Constitution) is being amended, the text of the existing provision will appear in this style type, additions will appear in **this style type**, and deletions will appear in ~~this style type.~~

Additions: Whenever a new statutory provision is being enacted (or a new constitutional provision adopted), the text of the new provision will appear in **this style type**. Also, the word **NEW** will appear in that style type in the introductory clause of each SECTION that adds a new provision to the Indiana Code or the Indiana Constitution.

Conflict reconciliation: Text in a statute in *this style type* or ~~*this style type*~~ reconciles conflicts between statutes enacted by the 2014 Regular Session and 2014 Second Regular Technical Session of the General Assembly.

HOUSE BILL No. 1043

A BILL FOR AN ACT to amend the Indiana Code concerning civil law and procedure.

Be it enacted by the General Assembly of the State of Indiana:

SECTION 1. IC 34-18-4-1 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2016]: Sec. 1. Financial responsibility of a health care provider and the provider's officers, agents, and employees while acting in the course and scope of their employment with the health care provider may be established under subdivision (1), (2), or (3):

(1) By the health care provider's insurance carrier filing with the commissioner proof that the health care provider is insured by a policy of malpractice liability insurance in the amount ~~of at least two hundred fifty thousand dollars ($250,000)~~ **equal to the health care provider's maximum liability under section 3(b) of this chapter** per occurrence and seven hundred fifty thousand dollars ($750,000) in the annual aggregate, except for the following:

(A) If the health care provider is a hospital, as defined in this

article, the minimum annual aggregate insurance amount is as follows:

(i) For hospitals of not more than one hundred (100) beds, five million dollars ($5,000,000).

(ii) For hospitals of more than one hundred (100) beds, seven million five hundred thousand dollars ($7,500,000).

(B) If the health care provider is a health maintenance organization (as defined in IC 27-13-1-19) or a limited service health maintenance organization (as defined in IC 27-13-34-4), the minimum annual aggregate insurance amount is one million seven hundred fifty thousand dollars ($1,750,000).

(C) If the health care provider is a health facility, the minimum annual aggregate insurance amount is as follows:

(i) For health facilities with not more than one hundred (100) beds, seven hundred fifty thousand dollars ($750,000).

(ii) For health facilities with more than one hundred (100) beds, one million two hundred fifty thousand dollars ($1,250,000).

(2) By filing and maintaining with the commissioner cash or surety bond approved by the commissioner in the amounts set forth in subdivision (1).

(3) If the health care provider is a hospital or a psychiatric hospital, by submitting annually a verified financial statement that, in the discretion of the commissioner, adequately demonstrates that the current and future financial responsibility of the health care provider is sufficient to satisfy all potential malpractice claims incurred by the provider or the provider's officers, agents, and employees while acting in the course and scope of their employment up to a total of ~~two hundred fifty thousand dollars ($250,000)~~ **the amount set forth in section 3(b) of this chapter** per occurrence and annual aggregates as follows:

(A) For hospitals of not more than one hundred (100) beds, five million dollars ($5,000,000).

(B) For hospitals of more than one hundred (100) beds, seven million five hundred thousand dollars ($7,500,000).

The commissioner may require the deposit of security to assure continued financial responsibility.

SECTION 2. IC 34-18-6-4, AS AMENDED BY P.L.18-2014, SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2016]: Sec. 4. (a) Claims for payment from the patient's compensation fund must be computed and paid ~~as follows:~~ **not later**

than sixty (60) days after the issuance of a court approved settlement or final, nonappealable judgment.

~~(1) Claims for payment from the patient's compensation fund that become final during the first three (3) months of the calendar year must be:~~

~~(A) computed on March 31; and~~

~~(B) paid not later than April 15;~~

~~of that calendar year.~~

~~(2) Claims for payment from the patient's compensation fund that become final during the second three (3) months of the calendar year must be:~~

~~(A) computed on June 30; and~~

~~(B) paid not later than July 15;~~

~~of that calendar year.~~

~~(3) Claims for payment from the patient's compensation fund that become final during the third three (3) months of the calendar year must be:~~

~~(A) computed on September 30; and~~

~~(B) paid not later than October 15;~~

~~of that calendar year.~~

~~(4) Claims for payment from the patient's compensation fund that become final during the last three (3) months of the calendar year must be:~~

~~(A) computed on December 31 of that calendar year; and~~

~~(B) paid not later than January 15 of the following calendar year.~~

(b) If the balance in the fund is insufficient to pay in full all claims that have become final during a three (3) month period, the amount paid to each claimant must be prorated. Any amount left unpaid as a result of the proration must be paid before the payment of claims that become final during the following three (3) month period.

SECTION 3. IC 34-18-6-5, AS AMENDED BY P.L.18-2014, SECTION 2, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2016]: Sec. 5. The auditor of state shall issue a warrant in the amount of each claim submitted to the auditor against the fund ~~on March 31, June 30, September 30, and December 31 of each year.~~ **not later than sixty (60) days after the issuance of a court approved judgment or final, nonappealable judgment.** The only claim against the fund shall be a voucher or other appropriate request by the commissioner after the commissioner receives:

(1) a certified copy of a final judgment against a health care provider; or

(2) a certified copy of a court approved settlement against a health care provider.

SECTION 4. IC 34-18-10-25 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2016]: Sec. 25. (a) Each health care provider member of the medical review panel is entitled to be paid:

(1) up to ~~three hundred fifty dollars ($350)~~ **five hundred dollars ($500)** for all work performed as a member of the panel, exclusive of time involved if called as a witness to testify in court; and

(2) reasonable travel expense.

(b) The chairman of the panel is entitled to be paid:

(1) at the rate of two hundred fifty dollars ($250) per diem, not to exceed two thousand **five hundred** dollars ~~($2,000);~~ **($2,500);** and

(2) reasonable travel expenses.

(c) The chairman shall keep an accurate record of the time and expenses of all the members of the panel. The record shall be submitted to the parties for payment with the panel's report.

(d) Fees of the panel, including travel expenses and other expenses of the review, shall be paid by the side in whose favor the majority opinion is written. If there is no majority opinion, each side shall pay fifty percent (50%) of the cost.

SECTION 5. IC 34-18-14-1 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2016]: Sec. 1. As used in this chapter, "cost of the periodic payments agreement" means the amount expended by ~~the health care provider (or its insurer),~~ the commissioner, ~~or the commissioner and the health care provider (or its insurer),~~ at the time the periodic payments agreement is made, to obtain the commitment from a third party to make available money for use as future payment, the total of which may exceed the limits provided in section 3 of this chapter.

SECTION 6. IC 34-18-14-2 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2016]: Sec. 2. As used in this chapter, "periodic payments agreement" means a contract between ~~a health care provider (or its insurer)~~ **the commissioner** and the patient (or the patient's estate) under which the ~~health care provider is relieved from~~ possible liability ~~in consideration of~~ **of the fund to the patient (or the patient's estate) is discharged through:**

(1) a present payment of money to the patient (or the patient's estate); and

(2) one (1) or more payments to the patient (or the patient's estate) in the future;

whether or not some or all of the payments are contingent upon the

patient's survival to the proposed date of payment.

SECTION 7. IC 34-18-14-3 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2016]: Sec. 3. (a) The total amount recoverable for an injury or death of a patient may not exceed the following:

(1) Five hundred thousand dollars ($500,000) for an act of malpractice that occurs before January 1, 1990.

(2) Seven hundred fifty thousand dollars ($750,000) for an act of malpractice that occurs:

(A) after December 31, 1989; and

(B) before July 1, 1999.

(3) One million two hundred fifty thousand dollars ($1,250,000) for an act of malpractice that occurs:

(A) after June 30, 1999; **and**

(B) before July 1, 2016.

(4) One million six hundred fifty thousand dollars ($1,650,000) for an act of malpractice that occurs after June 30, 2016.

(b) A health care provider qualified under this article (or IC 27-12 before its repeal) is not liable ~~for an amount in excess of two hundred fifty thousand dollars ($250,000)~~ for an occurrence of malpractice **in an amount in excess of the following:**

(1) Three hundred thousand dollars ($300,000), except as provided in subdivision (2).

(2) Four hundred thousand dollars ($400,000), if the action against the health care provider results in a final judgment in favor of the plaintiff.

(c) Any amount due from a judgment or settlement that is in excess of the total liability of all liable health care providers, subject to subsections (a), (b), and (d), shall be paid from the patient's compensation fund under IC 34-18-15.

(d) If a health care provider qualified under this article (or IC 27-12 before its repeal) admits liability or is adjudicated liable solely by reason of the conduct of another health care provider who is an officer, agent, or employee of the health care provider acting in the course and scope of employment and qualified under this article (or IC 27-12 before its repeal), the total amount that shall be paid to the claimant on behalf of the officer, agent, or employee and the health care provider by the health care provider or its insurer is ~~two hundred fifty thousand dollars ($250,000).~~ **the amount set forth in subsection (b).** The balance of an adjudicated amount to which the claimant is entitled shall be paid by other liable health care providers or the patient's compensation fund, or both.

SECTION 8. IC 34-18-14-4 IS REPEALED [EFFECTIVE JULY 1, 2016]. ~~Sec. 4. (a) If the possible liability of the health care provider to the patient is discharged solely through an immediate payment, the limitations on recovery from a health care provider stated in section 3(b) and 3(d) of this chapter apply without adjustment.~~

~~(b) If the health care provider agrees to discharge its possible liability to the patient through a periodic payments agreement, the amount of the patient's recovery from a health care provider in a case under this subsection is the amount of any immediate payment made by the health care provider or the health care provider's insurer to the patient, plus the cost of the periodic payments agreement to the health care provider or the health care provider's insurer. For the purpose of determining the limitations on recovery stated in section 3(b) and 3(d) of this chapter and for the purpose of determining the question under IC 34-18-15-3 of whether the health care provider or the health care provider's insurer has agreed to settle its liability by payment of its policy limits, the sum of:~~

~~(1) the present payment of money to the patient (or the patient's estate) by the health care provider (or the health care provider's insurer); plus~~

~~(2) the cost of the periodic payments agreement expended by the health care provider (or the health care provider's insurer);~~

~~must exceed one hundred eighty-seven thousand dollars ($187,000).~~

~~(c) More than one (1) health care provider may contribute to the cost of a periodic payments agreement, and in such an instance the sum of the amounts expended by each health care provider for immediate payments and for the cost of the periodic payments agreement shall be used to determine whether the one hundred eighty-seven thousand dollar ($187,000) requirement in subsection (b) has been satisfied. However, one (1) health care provider or its insurer must be liable for at least fifty thousand dollars ($50,000).~~

SECTION 9. IC 34-18-15-3 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2016]: Sec. 3. If a health care provider or its insurer has agreed to settle its liability on a claim by payment of ~~its policy limits of two hundred fifty thousand dollars ($250,000),~~ **the amount set forth in IC 34-18-14-3(b)(1)** and the claimant is demanding an amount in excess of that amount, the following procedure must be followed:

(1) A petition shall be filed by the claimant in the court named in the proposed complaint, or in the circuit or superior court of Marion County, at the claimant's election, seeking:

(A) approval of an agreed settlement, if any; or

(B) demanding payment of damages from the patient's compensation fund.

(2) A copy of the petition with summons shall be served on the commissioner, the health care provider, and the health care provider's insurer, and must contain sufficient information to inform the other parties about the nature of the claim and the additional amount demanded.

(3) The commissioner and either the health care provider or the insurer of the health care provider may agree to a settlement with the claimant from the patient's compensation fund, or the commissioner, the health care provider, or the insurer of the health care provider may file written objections to the payment of the amount demanded. The agreement or objections to the payment demanded shall be filed within twenty (20) days after service of summons with copy of the petition attached to the summons.

(4) The judge of the court in which the petition is filed shall set the petition for approval or, if objections have been filed, for hearing, as soon as practicable. The court shall give notice of the hearing to the claimant, the health care provider, the insurer of the health care provider, and the commissioner.

(5) At the hearing, the commissioner, the claimant, the health care provider, and the insurer of the health care provider may introduce relevant evidence to enable the court to determine whether or not the petition should be approved if the evidence is submitted on agreement without objections. If the commissioner, the health care provider, the insurer of the health care provider, and the claimant cannot agree on the amount, if any, to be paid out of the patient's compensation fund, the court shall, after hearing any relevant evidence on the issue of claimant's damage submitted by any of the parties described in this section, determine the amount of claimant's damages, if any, in excess of ~~the two hundred fifty thousand dollars ($250,000)~~ **the amount set forth in IC 34-18-14-3(b)(1)** already paid by the insurer of the health care provider. The court shall determine the amount for which the fund is liable and make a finding and judgment accordingly. In approving a settlement or determining the amount, if any, to be paid from the patient's compensation fund, the court shall consider the liability of the health care provider as admitted and established.

(6) A settlement approved by the court may not be appealed. A judgment of the court fixing damages recoverable in a contested

proceeding is appealable pursuant to the rules governing appeals in any other civil case tried by the court.

(7) A release executed between the parties does not bar access to the patient's compensation fund unless the release specifically provides otherwise.

COMMITTEE REPORT

Mr. Speaker: Your Committee on Judiciary, to which was referred House Bill 1043, has had the same under consideration and begs leave to report the same back to the House with the recommendation that said bill be amended as follows:

Page 1, between the enacting clause and line 1, begin a new paragraph and insert:

"SECTION 1. IC 34-18-4-1 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2016]: Sec. 1. Financial responsibility of a health care provider and the provider's officers, agents, and employees while acting in the course and scope of their employment with the health care provider may be established under subdivision (1), (2), or (3):

(1) By the health care provider's insurance carrier filing with the commissioner proof that the health care provider is insured by a policy of malpractice liability insurance in the amount ~~of at least two hundred fifty thousand dollars ($250,000)~~ **equal to the health care provider's maximum liability under section 3(b) of this chapter** per occurrence and seven hundred fifty thousand dollars ($750,000) in the annual aggregate, except for the following:

(A) If the health care provider is a hospital, as defined in this article, the minimum annual aggregate insurance amount is as follows:

(i) For hospitals of not more than one hundred (100) beds, five million dollars ($5,000,000).

(ii) For hospitals of more than one hundred (100) beds, seven million five hundred thousand dollars ($7,500,000).

(B) If the health care provider is a health maintenance organization (as defined in IC 27-13-1-19) or a limited service health maintenance organization (as defined in IC 27-13-34-4), the minimum annual aggregate insurance amount is one million seven hundred fifty thousand dollars ($1,750,000).

(C) If the health care provider is a health facility, the minimum annual aggregate insurance amount is as follows:

(i) For health facilities with not more than one hundred (100) beds, seven hundred fifty thousand dollars ($750,000).

(ii) For health facilities with more than one hundred (100) beds, one million two hundred fifty thousand dollars ($1,250,000).

(2) By filing and maintaining with the commissioner cash or surety bond approved by the commissioner in the amounts set forth in subdivision (1).

(3) If the health care provider is a hospital or a psychiatric hospital, by submitting annually a verified financial statement that, in the discretion of the commissioner, adequately demonstrates that the current and future financial responsibility of the health care provider is sufficient to satisfy all potential malpractice claims incurred by the provider or the provider's officers, agents, and employees while acting in the course and scope of their employment up to a total of ~~two hundred fifty thousand dollars ($250,000)~~ **the amount set forth in section 3(b) of this chapter** per occurrence and annual aggregates as follows:

(A) For hospitals of not more than one hundred (100) beds, five million dollars ($5,000,000).

(B) For hospitals of more than one hundred (100) beds, seven million five hundred thousand dollars ($7,500,000).

The commissioner may require the deposit of security to assure continued financial responsibility.

SECTION 2. IC 34-18-6-4, AS AMENDED BY P.L.18-2014, SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2016]: Sec. 4. (a) Claims for payment from the patient's compensation fund must be computed and paid ~~as follows:~~ **not later than sixty (60) days after the issuance of a court approved settlement or final, nonappealable judgment.**

~~(1) Claims for payment from the patient's compensation fund that become final during the first three (3) months of the calendar year must be:~~

~~(A) computed on March 31; and~~

~~(B) paid not later than April 15;~~

~~of that calendar year.~~

~~(2) Claims for payment from the patient's compensation fund that become final during the second three (3) months of the calendar year must be:~~

~~(A) computed on June 30; and~~

~~(B) paid not later than July 15;~~

~~of that calendar year.~~

~~(3) Claims for payment from the patient's compensation fund that become final during the third three (3) months of the calendar year must be:~~

~~(A) computed on September 30; and~~

~~(B) paid not later than October 15;~~

~~of that calendar year.~~

~~(4) Claims for payment from the patient's compensation fund that become final during the last three (3) months of the calendar year must be:~~

~~(A) computed on December 31 of that calendar year; and~~

~~(B) paid not later than January 15 of the following calendar year.~~

(b) If the balance in the fund is insufficient to pay in full all claims that have become final during a three (3) month period, the amount paid to each claimant must be prorated. Any amount left unpaid as a result of the proration must be paid before the payment of claims that become final during the following three (3) month period.

SECTION 3. IC 34-18-6-5, AS AMENDED BY P.L.18-2014, SECTION 2, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2016]: Sec. 5. The auditor of state shall issue a warrant in the amount of each claim submitted to the auditor against the fund ~~on March 31, June 30, September 30, and December 31 of each year.~~ **not later than sixty (60) days after the issuance of a court approved judgment or final, nonappealable judgment.** The only claim against the fund shall be a voucher or other appropriate request by the commissioner after the commissioner receives:

(1) a certified copy of a final judgment against a health care provider; or

(2) a certified copy of a court approved settlement against a health care provider.

SECTION 4. IC 34-18-10-25 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2016]: Sec. 25. (a) Each health care provider member of the medical review panel is entitled to be paid:

(1) up to ~~three hundred fifty dollars ($350)~~ **five hundred dollars ($500)** for all work performed as a member of the panel, exclusive of time involved if called as a witness to testify in court; and

(2) reasonable travel expense.

(b) The chairman of the panel is entitled to be paid:

(1) at the rate of two hundred fifty dollars ($250) per diem, not to exceed two thousand **five hundred** dollars ~~($2,000),~~ **($2,500);** and

(2) reasonable travel expenses.

(c) The chairman shall keep an accurate record of the time and expenses of all the members of the panel. The record shall be submitted to the parties for payment with the panel's report.

(d) Fees of the panel, including travel expenses and other expenses of the review, shall be paid by the side in whose favor the majority

opinion is written. If there is no majority opinion, each side shall pay fifty percent (50%) of the cost.

SECTION 5. IC 34-18-14-1 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2016]: Sec. 1. As used in this chapter, "cost of the periodic payments agreement" means the amount expended by ~~the health care provider (or its insurer),~~ the commissioner, ~~or the commissioner and the health care provider (or its insurer),~~ at the time the periodic payments agreement is made, to obtain the commitment from a third party to make available money for use as future payment, the total of which may exceed the limits provided in section 3 of this chapter.

SECTION 6. IC 34-18-14-2 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2016]: Sec. 2. As used in this chapter, "periodic payments agreement" means a contract between ~~a health care provider (or its insurer)~~ **the commissioner** and the patient (or the patient's estate) under which the ~~health care provider is relieved from~~ possible liability ~~in consideration of~~ **of the fund to the patient (or the patient's estate) is discharged through:**

(1) a present payment of money to the patient (or the patient's estate); and

(2) one (1) or more payments to the patient (or the patient's estate) in the future;

whether or not some or all of the payments are contingent upon the patient's survival to the proposed date of payment.".

Page 2, line 3, strike "for an amount in excess of".

Page 2, line 3, delete "three".

Page 2, line 4, strike "hundred".

Page 2, line 4, strike "thousand dollars".

Page 2, line 4, delete "($300,000)".

Page 2, line 5, delete "." and insert "**in an amount in excess of the following:**

(1) Three hundred thousand dollars ($300,000), except as provided in subdivision (2).

(2) Four hundred thousand dollars ($400,000), if the action against the health care provider results in a final judgment in favor of the plaintiff.".

Page 2, line 17, delete "three".

Page 2, line 17, strike "hundred".

Page 2, line 18, strike "thousand dollars".

Page 2, line 18, delete "($300,000)." and insert "**the amount set forth in subsection (b).**".

Page 2, after line 21, begin a new paragraph and insert:

"SECTION 7. IC 34-18-14-4 IS REPEALED [EFFECTIVE JULY 1, 2016]. ~~Sec. 4. (a) If the possible liability of the health care provider to the patient is discharged solely through an immediate payment, the limitations on recovery from a health care provider stated in section 3(b) and 3(d) of this chapter apply without adjustment.~~

~~(b) If the health care provider agrees to discharge its possible liability to the patient through a periodic payments agreement, the amount of the patient's recovery from a health care provider in a case under this subsection is the amount of any immediate payment made by the health care provider or the health care provider's insurer to the patient, plus the cost of the periodic payments agreement to the health care provider or the health care provider's insurer. For the purpose of determining the limitations on recovery stated in section 3(b) and 3(d) of this chapter and for the purpose of determining the question under IC 34-18-15-3 of whether the health care provider or the health care provider's insurer has agreed to settle its liability by payment of its policy limits, the sum of:~~

~~(1) the present payment of money to the patient (or the patient's estate) by the health care provider (or the health care provider's insurer); plus~~

~~(2) the cost of the periodic payments agreement expended by the health care provider (or the health care provider's insurer);~~

~~must exceed one hundred eighty-seven thousand dollars ($187,000).~~

~~(c) More than one (1) health care provider may contribute to the cost of a periodic payments agreement, and in such an instance the sum of the amounts expended by each health care provider for immediate payments and for the cost of the periodic payments agreement shall be used to determine whether the one hundred eighty-seven thousand dollar ($187,000) requirement in subsection (b) has been satisfied. However, one (1) health care provider or its insurer must be liable for at least fifty thousand dollars ($50,000).~~

SECTION 8. IC 34-18-15-3 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2016]: Sec. 3. If a health care provider or its insurer has agreed to settle its liability on a claim by payment of ~~its policy limits of two hundred fifty thousand dollars ($250,000),~~ **the amount set forth in IC 34-18-14-3(b)(1)** and the claimant is demanding an amount in excess of that amount, the following procedure must be followed:

(1) A petition shall be filed by the claimant in the court named in the proposed complaint, or in the circuit or superior court of Marion County, at the claimant's election, seeking:

(A) approval of an agreed settlement, if any; or

(B) demanding payment of damages from the patient's compensation fund.

(2) A copy of the petition with summons shall be served on the commissioner, the health care provider, and the health care provider's insurer, and must contain sufficient information to inform the other parties about the nature of the claim and the additional amount demanded.

(3) The commissioner and either the health care provider or the insurer of the health care provider may agree to a settlement with the claimant from the patient's compensation fund, or the commissioner, the health care provider, or the insurer of the health care provider may file written objections to the payment of the amount demanded. The agreement or objections to the payment demanded shall be filed within twenty (20) days after service of summons with copy of the petition attached to the summons.

(4) The judge of the court in which the petition is filed shall set the petition for approval or, if objections have been filed, for hearing, as soon as practicable. The court shall give notice of the hearing to the claimant, the health care provider, the insurer of the health care provider, and the commissioner.

(5) At the hearing, the commissioner, the claimant, the health care provider, and the insurer of the health care provider may introduce relevant evidence to enable the court to determine whether or not the petition should be approved if the evidence is submitted on agreement without objections. If the commissioner, the health care provider, the insurer of the health care provider, and the claimant cannot agree on the amount, if any, to be paid out of the patient's compensation fund, the court shall, after hearing any relevant evidence on the issue of claimant's damage submitted by any of the parties described in this section, determine the amount of claimant's damages, if any, in excess of ~~the two hundred fifty thousand dollars ($250,000)~~ **the amount set forth in IC 34-18-14-3(b)(1)** already paid by the insurer of the health care provider. The court shall determine the amount for which the fund is liable and make a finding and judgment accordingly. In approving a settlement or determining the amount, if any, to be paid from the patient's compensation fund, the court shall consider the liability of the health care provider as admitted and established.

(6) A settlement approved by the court may not be appealed. A judgment of the court fixing damages recoverable in a contested

proceeding is appealable pursuant to the rules governing appeals in any other civil case tried by the court.

(7) A release executed between the parties does not bar access to the patient's compensation fund unless the release specifically provides otherwise.".

Renumber all SECTIONS consecutively.

and when so amended that said bill do pass.

(Reference is to HB 1043 as introduced.)

STEUERWALD

Committee Vote: yeas 9, nays 2.